PSYCHOLOGY CASE RECORD

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By
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Most of all, I would like to thank The Almighty God for all His blessings.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Aiswarya R Nair** during the year 2014-2016. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD 1: Personality Assessment

Name : Ms P M

Age : 16 years

Sex : Female

Marital status : Unmarried

Religion : Hindu

Language : Bengali

Education : 10 th standard

Occupation : Student

Socio-economic status : Middle

Residence : Semi Urban

Informant : Ms PM and her father

Presenting Complaints

- Multiple attempts of deliberate self harm
- Adamant & Oppositional behaviour
- Frequent emotional breakdown
- Poor interpersonal relationship

Duration: Past 4 to 5 years

History of Presenting Illness

Ms PM presented to the hospital with history of vomiting and abdominal pain since 2 years. Initially the symptoms were very occasional, however there is history of worsening of symptoms since 5 months when she was diagnosed with acute appendicitis and underwent surgery for the same, following which she developed wound infection which was managed elsewhere. After this her symptoms of vomiting, abdominal pain and giddiness worsened. She was evaluated for the same by multiple specialists in Kolkata and in CMCH following which organic causes for her symptoms were ruled out and she was referred to MHC for further management. At presentation she had vomiting at least 5 times a day, which was precipitated by food. She also had abdominal pain and both the symptoms were interfering with daily activities.

There was no history suggestive of first rank symptoms.

There was no history of expressing false belief with conviction.

There was no history of any abnormal perception.

There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

There was no history of any substance abuse

Treatment history

She was extensively evaluated outside for organic causes and was started on Tab.Olanzapine for the same. She also gives history of galactorrhea even before Olanzapine treatment which had worsened after olanzapine treatment. She was referred to CMCH for further management. She was evaluated under the department of Gastroenterology as an inpatient and her investigations including CT abdomen, USG, MRI brain, EEG, blood investigations and gastric emptying time were all normal. Endocrinology opined the cause for Galactorrhea as probably drug induced (olanzapine and anti emetics).

Family history

She was borne out of a non-consanguinous marriage, as first born of a twin pregnancy. There is family history of abdominal wall carcinoma in mother and alcohol dependence in 4th degree relatives. Her father has remarried after the death of her mother and she currently lives with her father, step-mother, sister and step sister. There are adjustment issues in the family context.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be age appropriate.

Educational history

She is currently doing her 10th standard and has good scholastic performance.

Sexual development

She had female gender identity and heterosexual orientation. She denied any high risk sexual behaviour.

Premorbid personality

Since childhood she was described to be very adamant. She was described to have low frustration tolerance. She had frequent emotional turmoil and a chronic feeling of emptiness. Her numbers of friends were very limited and she had a close relationship with her twin sister who studied in her class.

Past history

History is suggestive of probable dissociative episode at 9 years of age and traumatic life event of mother's death occurring at 4 years of age.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits

Mental status examination

She was of normal built and was well kempt. Eye contact could be maintained. Rapport could be established. There was no restlessness. Her level of activity was normal. There were no abnormal involuntary movements. She was co-operative during the interview.

Her primary mental functions were normal. Attention and concentration could be aroused and was sustained. She had good immediate, recent and remote memory. She was oriented to time, place and person.

Her speech was of normal tone, pitch, reaction time and speed. Form and stream of thought were normal. Mild anxiety was also noted during interview. She had ideas of helplessness, hopelessness and worthlessness. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. She currently denied any suicidal ideas. There were no obsessions or compulsions. Her intelligence was normal and her insight was grade 3 with intact judgement.

Provisional Diagnosis

AXIS 1: Psychogenic vomiting;

Adjustment Disorder with prolonged Depressive Reaction

AXIS 2: Needs clarification for cluster B traits

AXIS 3: NIL

AXIS 4: Appendicities with post appendicectomy status.

AXIS 5: Multiple psychosocial issues, loss of biological mother at 4 years of age.

Psychometry

Aim for Psychometry: To identify and confirm significant personality traits influencing the psychopathology.

Tests administered

1. BDI-II-
2. Children's Eating Attitude Test
3. High School Personality Questionnaire (HSPQ)
4. Thematic Apperception Test (TAT
5. Sack's Sentence Completion Test (SSCT)

Behavioural observation

During the entire period of assessment, she was cooperative. She could comprehend the instructions and her attention was adequate. She appeared well motivated.

Rationale for the tests

1. Beck Depression Inventry (BDI) II

The **Beck Depression Inventory** (**BDI**, **BDI-1A**, **BDI-II**), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric for measuring the severity of depression. Each question has a set of at least four possible responses, ranging in intensity. Its development marked a shift among mental health professionals, who had until then, viewed depression from a psychodynamic perspective, instead of it being rooted in the patient's own thoughts.

In its current version, the BDI-II is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical

symptoms such as fatigue, weight loss, and lack of interest in sex. There are three versions of the BDI—the original BDI, first published in 1961 and later revised in 1978 as the BDI-1A, and the BDI-II, published in 1996. The BDI is widely used as an assessment tool by health care professionals and researchers in a variety of settings.

Test findings: She has scored only 12 out of the 21 questions and on clinical correlation there was no pervasivity to any of the reported symptoms and symptoms of feeling sad, not enjoying things as she used to and crying spells, thoughts of killing herself, changes in sleep and appetite were contextual. However feelings of self criticalness and of being punished and being worthless were chronic complaints and formed her schema of self.

2. Childrens Eating attitude test (EAT)

The **Eating Attitudes Test** (EAT) is a widely used standardized self-report measure of symptoms and concerns characteristic of eating disorders. The original 40-item version of the EAT was published in 1979; it was developed for a study to examine socio-cultural factors in the development and maintenance of eating disorders. A 1982 publication by Garner and colleagues described a 26-item refinement of the original test. It is intended primarily for adolescents and adults.

The EAT-26 has been particularly useful a screening tool to assess "eating disorder risk" in high school, college and other special risk samples such as athletes

Test Findings: Patient scored 54 in the test. The test showed her to have high risk behaviour and there after the topic was taken up during sessions and the test findings was discussed in great detail with her. It was gathered that there has been an increase in gastrointestinal symptoms after her surgery and as vomiting was immediately following

her meal; this made her guilty of eating and want to stay away from food and there for the high scores in these and related items were seen as contextual. The patient had only age appropriate worries regarding her physique.

3. <u>High School Personality Questionnaire</u> (HSPQ) is an objective personality test for adolescents containing 142 questions and gives the personality profile of an individual.

Test Findings: Her personality was characterized by impatience, sensitivity, individualism, easily troubled, compulsive, apprehensive, easily frustrated and venturesome.

4. **<u>Thematic Apperception Test</u> (TAT)** is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test Findings: There was an adequate productivity in terms of responses. Most of her themes revolved around people getting sick and later a positive ending and also of a benevolent all pervasive mother figure. It was also noticed that stomach was seen as a vulnerable site, in her body. This probably shows her unconscious desire to connect with her mother who died of abdominal cancer. It was evident that she felt victimised by people, circumstances but at one point seemed to enjoy the status. Grief about mother's death appeared several times which showed unresolved emotions. Self blame was predominant. The recurrent theme was that of need for care and nurturance. There was only one positive association with her step mother which was related to the care given by her during the time of her health problems. Conflicts in the domain of interpersonal relationship, especially in the family context were evident. Her needs were

predominantly motivated by affection, admiration, sympathy, love, and dependence. She attributes success in academics as a means of getting her fathers's love and admiration from others.

5. Sacks Sentence Completion Test (SSCT) is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test Findings: Findings revealed her attitudes and feelings towards significant people in her life as follows

Attitude towards mother:

She had negative feelings towards her step mother. There was a sense of resentment as she felt that her step-mother did not meet upto the ideal standards that she expected or desired of her. She yearned for the step mother's love.

She describes her biological mother as a loving person with whom she had shared a good relationship with. She also blames herself for her demise and questions why she left her early and fantasizes in spending more time with her. It appeared that she had not resolved her grief.

Attitude towards father:

She describes him as bad, critical and is afraid of him but maintains that she likes him.

Attitude towards family unit:

She mentioned that they are judgemental, insensitive and inconsiderate. She has idealistic expectations of the family and yearns for the past. Maintains close relationship with sister but tends to be defensive and competitive.

Attitude towards others:

She has Idealistic and unrealistic standards. She maintains that she is fearful of criticism and non acceptance from others.

Attitude towards self and future and fears:

There were guilt feelings, secretiveness and poor self disclosure. She sees herself as assertive, ambitious and confident but feels the need for others approval. There were also indications of homicidal and suicidal impulses. She maintains that she looks forward to her future but, at times mentions hopelessness.

Principal area of conflicts and disturbance were mother, father, family unit, fears, past and guilt feelings. Problems of close emotional tie with expired mother, unrealistic expectations with step mother and a lack of warmth in relationship with father and guilt about mother's death were other problems identified. Feeling of rejection in childhood leaves her insecure, constantly seeking approval, extremely goal oriented in academics as a means to achieve father's approval and feelings of rejection when she is unable to fulfil his expectations. Her responses are primarily to inner impulses, and she sees people in her life as all good or all bad. She also sets high, idealistic standards for others and self and tends to over evaluate her potential. She has need for recognition, acceptance and love which she expresses through bodily ailments thereby gaining attention.

Summary of Test Findings

The predominant personality characteristics that were elicited were that of a person who is emotionally insecure with strong feelings of rejection. There is unresolved grief and she appears to make an attempt to resolve it by living in the past, being unable to face reality by making adaptations or accommodations to it. She sees others as needing change and falling below the standards however is unable to view herself objectively. Her focus on bodily needs also reflects a primitive mode of gaining attention and nurturance using immature defences. Poor emotional regulation, unstable interpersonal relationships and feelings of emptiness are seen.

Diagnosis

AXIS 1: Psychogenic vomiting;

Adjustment Disorder with prolonged Depressive Reaction

AXIS 2: Cluster B Personality Traits

AXIS 3: NIL

AXIS 4: Appendicities with post appendicectomy status.

AXIS 5: Multiple psychosocial issues, loss of biological mother at 4 years of age

Management

Patient was admitted for further management of symptoms .At the time of admission both father and PM held a medical model for her symptoms .The differentials of depression and eating disorder were considered however there was no pervasive low mood and on further observation and clarification she was seen to have only age

appropriate concern about body image and the symptoms and pattern of vomiting which was not suggestive of an eating disorder.

Family was psychoeducated on the psychological model of illness and role of secondary gain and maladaptive coping strategies. Patient was also psychoeducated on the same and taught relaxation and anger management techniques. Differential reinforcement techniques for anger management were introduced. She was also allowed to ventilate and was supported. With the above mentioned strategies patient showed improvement in the first week of hospitalisation. However she had relapse of symptoms on addressing primary gain. Multiple psycho social stressors were elicited. She was also able to bring out her grief regarding mother's death. The possibility of pathological grief was considered, however her current concern and depressive cognitions were seen as part of an Adjustment disorder with depressive reaction and hence was started on SSRI for the same.

During sessions in the ward she showed resistance, anger outbursts and deliberate self harm, which was dealt with firm, limit setting, psycho education and differential reinforcement. The possibility of an evolving cluster B personality was considered. With the treatment she had improvement in giddiness, abdominal pain and multiple self reports of vomiting and emotional problems associated with it. Further plans in schooling and daily routine at home were discussed and she was discharged on advice for long term psychotherapy and family therapy.

CASE RECORD 2: Intelligence Assessment

Name : Master V N

Age : 3 years

Sex : Male

Religion : Hindu

Education : currently attending play school

Socio-economic Status : Middle

Informant : Parents

Reliability : reliable and adequate

Presenting complaints

Delay in attaining head holding – noticed at about 4 and a half months of age

Delayed response to name call-noticed at about 9 months

Delay in verbalisation-noticed at about 1 year

Lack of socialisation -noticed in play school.

History of presenting complaints

Master V was noticed to have delay in attaining developmental mile stones as compared to his elder brother from about 4 and a half months of age, when there was a delay in attaining head control. Subsequently parents noticed further delay in motor, speech and

developmental milestones , with him attaining walking after about 20 months. He developed social smile at 4 and a half months and recognised his mother at 6 months .He repeated syllabelles at 1 year and attained his first word at about 1 and a half years and till date had not attained full sentences.He enjoys play activities with a preference for solitary play. He started going to play school at about 2 and a half years and has irregular attendance and poor performance in school including peer activities.

No history of squint,visual impairment.

No history of any speech disorder or hearing impairment.

No history to suggest any eating or elimination disorder.

No history of seizure disorder or any other organicity.

Past history

There was no significant past medical, surgical or neuropsychiatric history. There was no history of any substance abuse.

Birth and development history

Antenatal history: His mother had a planned pregnancy, supervised antenatal period .She had done her routine blood work ups. Which were normal and ultrasounds during all three trimesters and foetus growth and development was corresponding to gestational age.There is no history of fever, Diabetes , hypertension or any significant antenatal events.

Perinatal: Delivered term at 38 weeks by Elective Caesarian Section. Indication for LSCS was history of previous LSCS.The Birth weight was 3.75 Kg and there were no Birth complications.

Postnatal: He was breast fed exclusively upto 3 months of age and thereafter he was also fed with formula feed . He is fully immunised for age. There is no history of any postnatal complications.

Emotional development and temperament

He was described to be a reserved child who enjoyed only solitary play. He was reportedly throwing temper tantrums if his demands were not met. He would ask for food when hungry and had an irregular sleep habit. He did not have any self-injurious behaviour so far.

School history

He started going to play school at about 2 and a half years and has irregular attendance and poor performance in school including peer activities.

Family history.

He was borne of a nonconsanguinous unioun , when his father and mother were aged 37 and 31 respectively. He has a elder brother aged 9 years currently studying in fourth standerd and has attained normal developmental milestones and has been doing well scholastically. There is no family history of intellectual disability or neuropsychiatric comorbidity.

Physical examination

All his vital signs and CVS, RS, GI and CNS systems were within normal limits.

Mental Status Examination

3 year old child adequately built and nourished for his age. He is consistent in his response to name call, has social smile currently but inconsistent response to name call.

He is able to play by self with doll appropriately .He has lateral gaze and is seen to be using others body to communicate his needs.

Tests administered

1. Gesell Development Schedule- Revised

2. Vineland's Social Maturity Scale

Rationale for the tests

Gesell Developmental Schedule-Revised or the GDS-R is a comprehensive multi-dimensional assessment system that assists in understanding characteristics of child behavior in relation to typical growth patterns from 1 month to 72 months. It evaluates a child's adaptive ,gross motor ,fine motor ,language, personal and socio adaptive milestones. A child's performance on each strand corresponds to a developmental Age.

Vineland Social Maturity Scale was used to assess the social adaptive functioning level.

The test consists of 8 sub-scales measuring Communication skills, self-help ability, locomotion skills, occupation skills, self-direction, self-help eating ,self-help dressing and socialization skills

Test findings

Gesell Development Schedule Interpretation

Adaptive functioning-24 months

Gross motor-30 months

Fine motor-24 months

Language-18 months

Personal and social-21 months

Developmental age-23 months

Developmental Qoutient-65(mild developmental delay)

VSMS Interpretation

Selfhelp general; was assessed was to be at 1.98 years,

Self help dressing; was assessed to be at 2.6 years,

Self help eating; was assessed to be at 2.43 years ,

communication ;was assessed to be at 1.70 years,

socialisation ; was assessed to be at 1.5 years,

locomotion; was assessed to be at 1.75 years

occupation ;was assessed to beat 2.03years.

Social age is 1year 9 months.

Conclusion.

The child had mild developmental delay with developmental age at 23 months

and social age at 21 months

Management

1. The parents were allowed to ventilate, supported and psycho educated about the delay in development and its consequences.

2. The delay in milestones , especially in the language milestones were communicated to parents. A plan to do ADOS , was made as the delay was assessed to be more in the language and socioadaptive milestones and therefore to screen for autism.

3 .Routine blood investigations as well as specific like TSH was done to look for causes of developmental delay.

4. It was also suggested to the parents to put the child through the intensive training programme for 3 months as the child's developmetal delay was picked up at a very early age and significant benefits could be expected

5. The programme would include early intervention strategies , screening for comorbidities, speech therapy, and psychoeducation for parents including a home programme for the same. .

6.They were also introduced to the home programme which includes strategies for stimulation of the child, training in semi skilled and activities of daily living compatible with his age and also elementary steps in social skill training.

CASE RECORD 3: DIAGNOSTIC CLARIFICATION

Name : Miss V

Age : 23 Years

Sex : female

Marital status : Unmarried

Religion : Hindu

Language : Tamil

Education : B. Tech

Occupation : Currently unemployed for 1 month

Socio-economic status : Middle

Residence : Urban

Informant : Self and her parents

Presenting Complaints

- Decreased energy, crying spells, unable to pursue job, decreased sleep - for one and half months
- Keeping away from friends, crying spells for no specific reason, unspecified fear, fear of death and being alone, night mares, disturbed sleep- for one and half months
- Worsening of feelings of emptiness, violent and impulsive behavioural explosions, suicidal threats and self harming behaviour - for one and half months
- Decreased energy, crying spells, difficulty and lack of motivation to pursue job and difficulty to concentrate-for about a year.

History of Presenting Illness

Over the course of last 1 year the patient gives history of decreased energy, crying spells, difficulty and lack of motivation to pursue job and difficulty to concentrate. In the last one month or so, she has been keeping away from friends, having crying spells for no specific reason and expressing vague and unspecified fear, fear of death and also of being alone. In the same period, patient has been constantly ruminating about self and has been feeling increasingly hopeless and helpless, which has been secondary to interpersonal issues at home and work. She also started having frequent night mares, poor sleep with difficulty to initiate sleep and vivid dreams after which she wakes up feeling fearful. She also gives history of being hyper vigilant of late and reacts with a startle response to any loud sound, especially so at night. In the last one month she is observed to be having frequent interpersonal issues with her hostel mates and colleagues, as a result of which she quit her job at the place where she was working for one year and the hostel she was staying in the last year. At home, where she returned after quitting, her mother and other family members have noticed her to be having increasingly violent and impulsive behavioural explosions with father, sister and mother. She has been seen to having an increase in her throwing behaviour and frequently lashing at family members after verbal spats. She has also been making suicidal threats and expressing self harming behavior. There is also history of two deliberate self harm attempts in the last one month; one in her hostel when she took 5 tablets of unknown tablets but suffered no consequences and the other following a fight at home with her sister, she tried to slash her wrist in an attempt to let out anger, following which she experienced some relief. Subjectively she reports worsening of feelings of emptiness and feeling rejected by family and friends due to which she feels insecure, empty and rejected, which in turn acts as a stimulus for further fights and has been further worsening interpersonal relationships with friends and family. She perceives this and her current unemployed status as yet another stressor.

There was no history of expressing false belief with conviction.

There was no history of any abnormal perception.

There was no history of syndromal mood.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

There was no history of any substance abuse.

Family History

There is family history of schizophrenia in two paternal aunts, psychotic illness and completed suicide in paternal first cousin, seizure disorder in one paternal aunt and also alcohol use in father and marital discord in parents.

Premorbid Personality

Premorbid personality is described as short tempered, with low frustration tolerance and impulsivity .She is sociable with a good circle of friends, and is an achiever in academics and very ambitious regarding her carrier.

Past History

There is past history of Bronchial Asthma from childhood and recurrent respiratory tract infections from child hood.

Past Psychiatric History

There is history of a deliberate self harm attempt a year ago, she attempted to consume phenol impulsively after a fight, she denies prior planning and was discovered by family members as bathroom door was left open. It was suggestive of a low intentionality attempt and was following a suicide threat.

Mental Status Examination

Patient was thinly built and nourished, she maintained good eye contact, had normal posturing and activity, with normal adaptive and non adaptive movements, spontaneous speech with normal reaction time. Content of speech was relevant. Her mood was dysphoric with crying spells and she expressed suicidality. She expressed amotivation, ideas of hopelessness and worthlessness. She was oriented to time, place and person, attention and concentration was intact with general information and abstract thinking being average. She had awareness of symptoms, of being mentally ill and willingness to take treatment, with grade 3 insight and impaired personal and social judgement and intact test judgement.

Provisional Diagnosis

- Schizophrenia; prodromal stage
- Moderate depression with psychotic symptoms
- Emotionally Unstable Personality Disorder- Impulsive type
- Adjustment disorder; brief depressive reaction

Psychometry

Rationale for Psychometry

As mentioned in the history, her symptoms were nonspecific but the dysfunction was prominent. She also had high anxiety. Many of her present symptoms and past history also pointed towards an underlying personality disorder. Mental status examination did not reveal any clear cut psychotic or core depressive symptoms but she expressed suicidal ideation. In the back ground of strong family history, past history and premorbid personality the tests were undertaken.

Tests Administered

1. Hamilton Depression rating scale
2. Sacks Sentence Completion Test
3. IPDE –ICD 10 module
4. Rorshach Test

Behavioural observation

During the entire exercise, she was cooperative. She could comprehend the instructions and paid adequate attention. She appeared well motivated.

Rationale and Findings

1. **Hamilton Depression Rating Scale (HAM-D) –** developed by Max Hamilton (1959) contains 17 symptom oriented questions with a severity rating of 0 to 2.

Test findings: She scored 13 in the questionnaire, which showed mild depression but all the domains in which she scored more than 1 were contextual and in response to her newly unemployed status and interpersonal conflicts with friends and family. She had no symptoms of biological depression like psychomotor retardation, decreased appetite, weight loss and diurnal variation of symptoms. She had difficulty in sleep initiation which caused significant distress.

2. <u>Sacks Sentence Completion Test</u> is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test Findings: She is seen to have maximum conflicts towards her father, attitude towards colleagues at work, on her fears, goals and attitude towards future and mild conflicts in areas of attitude towards family unit, supervisors and supervised, own abilities and about her past. She has no conflicts in the areas of attitude towards mother, friends and woman.

She maintains that she has a vague non specific fear, probably of a presence she feels at times immediately after she wakes up with disturbed sleep. She also expresses murderous and suicidal impulses and frankly blames her colleagues for her present state. Her responses are primarily to inner impulses, and she sees people in her life as all good or all bad. She also sets high, idealistic standards for others and self and sees people as all good or all bad. Her responses are primarily to inner impulses, and she often reacts impulsively to situations. It was also evident that her problem solving strategies were poor and she had an emotionally focused problem solving strategy.

3. International Personality Disorder Examination (IPDE) was developed within the joint programme for the diagnosis and Classification of Mental Disorders of the World Health Organisation (WHO) and U.S. National Institutes of Health (NIH) and provides a uniform approach for assessing personality disorders for both the DSM-IVTM and the ICD-10 classification systems. The interview is the most widely used and the manual contain a self administered screening questionnaire and a semi structured interview booklet with scoring material.

Test Finding: She has scored more than 3 in many personality types; she has scored 3 with schizoid traits, 6 with dissocial traits, 4 with borderline traits, 5 with anxious traits, 4 with dependent traits.

She has predominantly scored high on cluster B traits. Anxiety and schizoid traits as per patients report was state dependent.

4. Rorshach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology

Test Findings: Rorshach test was attempted but the numbers of responses were less than 16 and hence the score could not be interpreted using the Exner's method. However, the raw score had certain popular responses and were not suggestive of psychosis.

Summary of Test Findings

Depression was ruled out after the tests and the results were not suggestive of frank psychosis and were suggestive of cluster B traits. It also threw light into patient's poor coping strategies, emotionally focused problem solving strategies and some cognitive errors including dichotomous thinking, and personalization. Multiple stressors including

ongoing conflicts were also apparent with the tests and proved to be valuable information for therapeutic strategies as well as alerted us further about her suicidal risk.

Diagnosis

- Adjustment disorder; brief depressive reaction
- Emotionally Unstable personality disorder- Impulsive type

Management

The initial management was targeted towards management of the crisis. She was advised hospital admission in view of her suicidal ideation and a no suicide contact was made. She was monitored regularly and was encouraged for regular follow up. She was allowed to ventilate, validated and supported during the crisis. It was also picked up that there was a change in her pattern of sleep following her quitting her job and therefore she was psychoeducated about the sleep hygiene practices also. She was also explained the need and benefits of continuing psychotherapy.

The family members were allowed to ventilate, supported and psycho educated about the illness, and also explained about suicidal precautions and the need for continued psychotherapy beyond crisis management. They were also informed to keep the patient under follow up.

CASE RECORD 4: Diagnostic Clarification

Name : Miss.S

Age : 15 Years

Sex : female

Marital status : Unmarried

Religion : Hindu

Language : Tamil

Education : studying in 11 th standard

Occupation : Student

Socio-economic status : Middle

Residence : Semi urban

Informant : Self and her parents and sister

Presenting complaints

Shivering in the right lower limb and upper limb and left lower limb-2 months

History of presenting illness

She was doing well till 2 months ago when she started experiencing shivering in the right lower limb. Initially the movements were occasional but within a period of next one week it became continuous throughout the day. Meanwhile it started involving left lower limb followed by right upper limb within a period of next one month. Left upper limb was spared. These movements were present during most of activities like playing, eating, studying or doing household work. They were reduced during the sleep. She yet continued to be functional and was going to school regularly. She was not able to control these movements. Her biological functions were normal. There is no history of psychosis, mood, seizures, trauma to head or substance abuse. No history of weakness, imbalance or sensory loss.

Treatment history

Initially she was started on Gabapentin, Haloperidol, Sertraline and Clonazepam from a local Neurologist but she continued to be same without further improvement. She was admitted in Pediatric Neurology in CMCH and organicity was ruled out. Haloperidol was stopped, while Gabapentin and Clonazepam were advised to be tapered and stop. Sertraline 50 mg per day was continued and she was reffered to Mental Health Centre.

Family history

There is family history of epilepsy in maternal cousin, there is no family history of any other neuropsychiatric illness.

Birth and developmental history

She was born of planned, supervised, uneventful full term pregnancy by normal vaginal delivery.

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. birth cry was delayed by less than 5 minutes ,otherwise was uneventful. The developmental milestones were reported to be normal.

Educational and Occupational history

She had good scholastic performance and passed 10 th standard with 471/500 marks

Premorbid personality

She is described as a sensitive , reasponsible individual who is well adjusted

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was conscious and alert during examination. Well kempt, cooperative, maintaining eye contact. Well oriented with time place and person. Her higher mental functions were

normal. No hallucination and delusion was reported. She had only partial insight into illness, though her judgment was intact.

Investigations: EEG: Normal.

USG Abdomen: Normal.

Provisional diagnosis

- Dissociative motor disorder

Differential diagnosis

- Generalised anxiety disorder
- Mild depression with somatic symptoms

Tests administered

5. Sacks Sentence Completion Test
6. Thematic Apperception Test
7. Bells Adjustment Inventory
8. Hamilton Anxiety Rating Scale
9. Hamilton Depression Rating Scale
10. SCARED
11. BDI-II

During the entire assessment, she was cooperative. She could comprehend the instructions and paid adequate attention. She e appeared well motivated.

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Rationale and Findings

1. Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception

Interpretation

In the test ,it was observed that she expressed severe conflicts in attitude towards friends, supervisors .She expresses feelings of rejection and seclusion from friends,she also expresses severe conflicts with interpersonal issues, supervision with guilt feelings, attitude towards own ability and mild conflict in attitude towards mother, women were present. She expresses a lot of positive feelings towards people who give more attention towards her symptoms .It was evident that she tends to avoid stressful or difficult situation and is fearful of the same .She anticipates worse situations and expresses unexplained fear and wishes to be away from fearful situations and thoughts. She expresses ambivalence towards mother expressing both extremes of positivity and negative feelings .Her regard and probable attatchment towards friends in old school was evident and the school change appeared to be a crisis for her. Her goal is to have good health and strive for achievements.

2. Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to

ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Interpretation

Inner states frequently encountered in her were conflicts of uncertainty and dejection .

The press are uncongenial rejecting environment, sympathy,respect and love .She attributes success with the support of others. Occassional impediments faced by protagonists were discrimination ,which includes violence and unspecified problem.

3. The Bell's Adjustment Inventory is a self-report of the individual's life and adjustment as he has experienced them. This inventory is designed to measure the various levels of adjustment on 4 areas of adjustment, namely, Home adjustment, Health adjustment, social and emotional adjustment.

Interpretation

She showed unsatisfactory adjustment in home and social spheres and average adjustment in health and home spheres.It showed her to be high on problem avoidance , wishful thinking ,expressed emotions ,and social withdrawal and capable of cognitively restructuring a situation to her disadvantage

It showed her coping strategies to be predominantly emotion focused engagement and problem focused disengagement.

4. Hamilton Anxiety Rating Scale (HAM-A) – developed by Max Hamilton (1959) contains 14 symptom oriented questions with a severity rating of 0 (not present) to 4 (Very Severe). Administration time is about 10-20 minute

5. Hamilton Depression Rating Scale (HAM-D) – developed by Max Hamilton (1959) contains 21 symptom oriented questions with a severity rating of 0 (not present) to 2 (Severe).

Interpretation

In Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale

She scored only 2 each and thereafter depression and anxiety were ruled out.

6. The Screen for Child Anxiety Related Disorders (SCARED) is a 41-item inventory rated on a 3 point Likert-type scale. It comes in two versions; one asks questions to parents about their child and the other asks these same questions to the child directly. The purpose of the instrument is to screen for signs of anxiety disorders in children.The one we used is the child version , where the child was asked to circle an answer which describes her in 3the last 3 months.

In **SCARED** she scored 24, which was not significant for anxiety ,she also scored 2 marks in the likeart scale for situations or questions related to school and meeting new people ,she didnot have a score indicative of generalized anxiety disorder, separation anxiety disorder ,social anxiety disorder or school avoidance.

7. <u>Beck Depression Inventry (BDI) II</u>

The **Beck Depression Inventory** (**BDI**, **BDI-1A**, **BDI-II**), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric for measuring the severity of depression. Each question has a set of at least four possible responses, ranging in intensity. Its development marked a shift among mental health professionals, who had until then, viewed depression from a psychodynamic perspective, instead of it being rooted in the patient's own thoughts.

In its current version, the BDI-II is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. There are three versions of the BDI—the original BDI, first published in 1961 and later revised in 1978 as the BDI-1A, and the BDI-II, published in 1996. The BDI is widely used as an assessment tool by health care professionals and researchers in a variety of settings.

Interpretation

She scored only 3 in BDI-II, and thereafter depression was ruled out

Conclusion

Her psychological assessment revealed no symptoms of depression and anxiety, but it revealed unsatisfactory adjustment in home and social environment. It also revealed her coping styles were predominantly emotion focused and problem avoidance. Severe conflicts were found in self-concept and interpersonal areas with mild conflict in family and sexuality. Her needs were predominantly motivated by affection, admiration, sympathy, love, dependence and emotional aggression.

Inner states encountered during the testing were conflicts of uncertainty and dejection . The press encountered were uncongenial rejecting environment, sympathy, respect and love .She attributes success with the support of others.

Diagnosis

- Dissociative Motor Disorder.

Management

She was advised to take her medication regularly and start following an activity schedule and was encouraged to go for regular OT classes. She was taught relaxation technique and physical exercises. She was continued on Sertraline 50 mg, while Clonazepam and Gabapentin was tapered and stopped as per plan from Pediatric Neurology.

Sessions were conducted to work on family dynamics, conflicts and to teach her copying methods and psycho-educate her about the illness. Gains were cut down and family was psycho-educated about the illness and management plan. She was doing her relaxation exercises and physical exercises regularly, and was regular to occupational therapy sessions. She improved on this and her involuntary movements were reduced considerably, especially when she was busy in her activities and was not giving attention to the movements. Her overall performance was improved and she was able to follow her activity daily schedule regularly.

Recommendations:

1) To continue with: Tab Sertraline 50 mg AMOD
2) To continue with relaxation techniques and physical exercises regularly.
3) To follow her activity schedule regularly.

CASE RECORD 5 : NEUROPSYCHOLOGICAL ASSESSMENT

Name : Mr MH

Age : 78 years

Sex : Male

Marital status : Married

Religion : Islam

Language : Malayalam

Education : 9th standard

Handedness : Right

Socio-economic status : High

Residence : Semi urban

Informant : Wife and brother

Presenting Complaints

- Memory impairment - one and half years
- Indecisiveness, difficulty to continue his vocation - one and half years
- Loss of interest in previously pleasurable activities - one and half years

History of Present Illness

Mr. MH was reportedly functioning well till one and half years back when he began to complain of having difficulty in remembering recent information and events and difficulty in making decisions. He would frequently forget to take his medications and often did not remember if he had taken or not. He would also forget whether he has observed his daily prayers or not. He had difficulty in remembering where he kept things and would often misplace them. He had difficulty in recollecting information and would often take a long time to answer simple questions. He began to have difficulty in making planning his things including his daily routine and performing them accurately. His socialization gradually declined and he began to avoid all social gatherings. He stopped reading newspapers and magazines, which he used to enjoy doing earlier. He gradually began to express feeling low throughout the day and began to wake up much earlier in the morning than he used to normally. He began to get fatigued easily and became more lethargic. His interest in activities that he enjoyed earlier declined gradually and his face often appeared dull. His interaction with his family members also gradually began to decline. He remained independent in his activities of daily living and did not require prompts for them. Despite his disinterest in pursuing his volition and indecisiveness, he was able to prepare and render speeches for meetings.

There was no history of head injury, difficulty in speech or apraxia

There was no history suggestive of psychosis, syndromal depression or mania.

There was no history of apathy or sexual disinhibition.

There was no history of obsessions or compulsions or phobia or panic attacks.

There was no history of deviant personality traits.

Treatment history

He was extensively evaluated in neurology department for his symptoms and a diagnosis of mild cognitive impairment was considered. However as the cognitive deficits did not adequately explain the extent of impairment and socio occupational decline, the possibility of functional over lay was considered and there after he was referred to psychiatry for further management.

Family history

He is the second of fifteen children born of a non-consanguineous union .Of his siblings, five people had expired due to medical and age related causes. There is family history of mood disorder in a younger sister, who is on treatment for the same and history of mental retardation in two nephews.

Developmental history

He was born of a non-consanguineous union and borne of full term normal vaginal delivery. Details regarding his neonatal and postnatal period were unavailable.

Educational history

He has been formally educated up to class ten where he failed and thereafter discontinued his studies. He is very well read in his mother tongue and was up to date with current events and is a very good orator.

Occupational history

He currently functioned as the general secretary of an orphanage run by his extended family.

Sexual History

His sexual orientation is heterosexual. There is no history of any sexual dysfunction.

Premorbid Personality

He was an active, hardworking sociable and responsible individual with good religious and moral standards.

Physical Examination

His vitals were stable. He had a mask like facial expression.

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

Involuntary Movements - Resting tremors present involving his upper extremities, predominantly right thumb and left index fingers

Reflexes: Deep tendon reflexes - 2+ bilaterally

Plantar reflex - Flexor bilaterally

Superficial abdominal reflex - Present all four quadrants

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Short steps with reduced arm swing

Meningeal signs - Absent

Skull and spine - Normal

Higher cognitive functions- MMSE - 20/30

Mental Status Examination

Mr.MH was moderately built. He was well kempt and was maintained eye contact. His facial expression was mask like. Rapport could be established. His posture was erect with mild psychomotor retardation. His speech was hesitant and slow with decreased tone and increased reaction time. Mood was euthymic, with restricted range and constricted affect. He denied any suicidal ideation. There was no formal thought disorder. His content of thought revealed distress about tremors but he denied depressive cognitions, delusions or obsessions. He denied having any perceptual abnormalities. He was oriented to time, place and person. His recent memory was impaired. His remote memory was intact and immediate memory showed mild deficit during recall. His abstract thinking was normal. His intelligence was average. He had grade intellectual insight into illness. His personal, social and test judgment were normal.

DIFFERENTIAL DIAGNOSIS

- Dysthymia with mild cognitive deficits
- Dementia with depression

AIMS FOR NEUROPSYCHOLOGICAL TESTING

1. To find out the cognitive profile of Mr MH

2. To relate the findings to clinical presentation

TESTS ADMINISTERED

NIMHANS Neuropsychological Battery

Behavioural Observation:

He was cooperative for the assessment and was able to sustain his attention for the test duration. However, in view of fatigue, the assessment had to be split into sessions. There was no active resistance in doing the assessment. He was able to comprehend the instructions well. His verbal communication was adequate. There was no performance anxiety observed. He did not make any attempts for any of the delayed recall trials in subtests. There was significant resting tremors observed.

Rationale:

NIMHANS Neuropsychological Battery (2004) -- The battery was developed by Shobini Rao et al in 2004. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population. For this patient, flexible battery approach was used and only specific subtests from the battery were chosen.

TEST FINDINGS

Mental speed

On the digit symbol substitution test, the total time taken to complete was 803s which is below the 3rd percentile, indicative of significant impairment in mental speed.

Attention

Sustained attention

On the digit vigilance test, the total time taken to complete was 836s which is at the 21st percentile, and the total number of errors was 25, which was at the 12th percentile. This is indicative of no impairment in sustained attention.

Focussed Attention

On the Colour Trails Test A, the total time taken to complete was 62s and the total time taken to complete colour trails Test B was 191s indicative of no impairment in focussed attention.

Divided Attention

On the Triads Test, the total errors was 2, which is at the 94th percentile, indicative of no impairment in his ability to divide attention between two tasks.

Executive functions

Phonemic fluency

Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average new words generated was 4.67 which is at the 25th percentile and is indicative of no significant impairment in phonemic fluency.

Categorical fluency

Was assessed by the Animal Names Test. The average new words generated was 6, which was below the 5th percentile, indicative of impairment in categorical fluency.

Response Inhibition

Response inhibition was assessed by the Stroop Test. The Stroop Effect was found to be 411.84 which is at the 3rd percentile, indicative of significant impairment in response inhibition.

Planning

Planning was assessed by the Tower of London Test. The total number of problems solved in the minimum number of moves is 6, which is at the 10th percentile. The mean time taken, the mean moves and the number of problems solved with minimal moves are as follows,

Number of moves	**Time taken**	**Percentile**	**Mean moves**	**Percentile**	**Number of prob. with minimal moves**
2 moves	14.24s	<3rd	2.5	100th	1
3 moves	53.79s	6th	4.75	22nd	2
4 moves	25.915	34th	4.75	76th	2
5 moves	90.39s	<3rd	10.5	16th	1

The scores suggest impairment in problem solving ability. There is fluctuation in the score which could be due to poor attention as the patient was able to conceptualize the problem and avoided making similar errors.

Learning and Memory

Verbal Learning and Memory

On the auditory verbal and learning test, the total number of correct words recalled is 27, which is below the 5th percentile; He did not attempt to do the immediate recall and delayed recall trials. The number of hits in the recognition trial is 12 which is at the 25th percentile. This indicates the presence of deficits in verbal learning and memory with recognition relatively preserved.

On the Logical Memory Test, he was able to recall 7 details in the immediate recall trial which is at the 20th percentile and but did not attempt to do the delayed recall trial.

Visuo - spatial construction and visual learning and memory

On the ROCF, the copying score is 33, which is at the 60th percentile. He did not attempt the immediate and delayed recall trials.

CONCLUSION

The test findings suggest impairment in the domains of mental speed, categorical fluency, response inhibition with delayed recall in verbal memory and visual memory not being attempted. Not all areas of executive functions are impaired with the patient's problem solving ability, lexical fluency and working memory relatively intact. Patient's tremulousness may also have interfered in some of the tests involving motor functions. The profile of deficits seen is not consistent with dementia. Intact attention and visuo constructive ability, impaired verbal memory and variation in performance across domains is suggestive of cognitive deficits associated with depression.

MANAGEMENT

Mr MH was admitted on a voluntary basis, for diagnostic clarification and for managing his cognitive symptoms as well as depressive symptoms. After the clarification he was started on anti depressants. The temporal correlation of the stressor and his symptoms was reflected back to him. He was encouraged to recall daily life events, newspaper headings and the names of various family members and also engaged in topics in which he showed great interest premorbidly. His recall of information improved with repeated prompts and encouragement. Attempts were made to explore the interpersonal problems. His wife was the caregiver during the admission and despite repeated requests his sons did not come to the hospital to discuss relevant issues which therefore could not be discussed fully. He was encouraged to go for regular walks and occupational therapy. Family members were educated about the role of stress in precipitating and perpetuating depressive symptoms.